Pharmacy

PDE-5 Inhibitors

Vardenafil (Levitra®,Staxyn®) Sildenafil (Viagra®) Tadalafil (Cialis®)

Prior Authorization Criteria for the TRICARE Pharmacy Program

Prior authorization for PDE-5 inhibitors is NOT required for male patients 40 years of age or older being treated for erectile dysfunction with Viagra. Prior authorization IS required for male patients less than 40 years of age being treated for erectile dysfunction, for ALL new erectile dysfunction patients being treated with Cialis, Staxyn or Levitra, and for ALL patients being treated for primary pulmonary hypertension, Raynaud's phenomenon, benign prostatic hyperplasia, and post-prostatectomy uses.

Coverage IS provided for:

- PDE-5 inhibitors for male patients 18 to 39 years of age with an approved prior authorization for:
    - Organic erectile dysfunction (e.g., diabetes-related, vascular-related); or
    - Mixed organic/psychogenic erectile dysfunction; or
    - Drug-induced erectile dysfunction where the causative drug cannot be altered or discontinued.
- PDE-5 inhibitors for male patients with erectile dysfunction, 40 years of age and older.
    - Sildenafil (Viagra) – no prior authorization form required
    - Vardenafil ODT (Staxyn), Vardenafil (Levitra) or tadalafil (Cialis) – step therapy PA applies (See criteria below).

- Sildenafil (Revatio or Viagra) or tadalafil (Cialis or Adcirca) for any patient with primary pulmonary hypertension. Sildenafil (Viagra) vardenafil (Levitra) or tadalafil (Cialis) for any patient with Raynaud's phenomenon or preservation and/or restoration of erectile function post-prostatectomy.

- Tadalafil 5 mg (Cialis 5mg) for patients with benign prostatic hyperplasia (BPH) meeting prior authorization criteria listed below.

Coverage IS NOT provided for:

- Female sexual dysfunction, or
- Erectile dysfunction in males under 18 years of age, or
- Psychogenic erectile dysfunction

Quantity Limits

• Treatment of Erectile Dysfunction – The PDE-5 inhibitors are limited to a maximum of 18 tablets per 90 days from the MOP or 6 tablets per 30 days from retail network pharmacies. This quantity limit applies collectively to all three medications. This means that no more than 18 tablets per 90-day supply of any combination of these medications will be dispensed in the TRICARE Mail Order Pharmacy and no more than 6 tablets per 30-day supply of any combination of these medications will be dispensed by retail network pharmacies. (Note: Staxyn (vardenafil ODT) is available in packages of four (4) tablets each. The Mail Order Pharmacy cannot break packaging and must dispense this product in multiples of 4.)

• Treatment of Pulmonary Arterial Hypertension, Raynaud's phenomenon, post-prostatectomy preservation/restoration of erectile function, Benign Prostatic Hyperplasia (BPH) - Usual rules apply (90-day supply in the MOP or 30-day supply at retail network pharmacies, based on the directions for use on the prescription).

• Use of Multiple Pharmacy Points of Service – The amount of medication obtained by a patient from all Military Health System pharmacy points of service will be taken into account in the application of this quantity limit.

(Criteria approved July 2004 by the DoD Pharmacy & Therapeutics Committee, revised July 2009; December 2009)

Medical necessity forms are available on the TRICARE Pharmacy website at www.tricare.osd.mil/pharmacy/medical-nonformulary.cfm.

Criteria approved through the Uniform Formulary decision-making process.

Cialis (tadalafil) Prior Authorization Request Form

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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at **http://pec.ha.osd.mil/forms_criteria.php**. This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please consider the following:**

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 **1. Please indicate the patient's gender.**

Female	Please go to **Section 1** for **Female patients** on this page
Male	Please go to **Section 2** for **Male patients** on page 2

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	Yes **Coverage not approved**	No Proceed to Question **2**
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	Yes **SKIP** to Question **4**	No Proceed to Question 3
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	Yes Proceed to Question **4**	No **Coverage not approved**
4. What is the dosing regimen?		

Please go to Step 4 on Page 2.

Cialis (tadalafil) Prior Authorization Request Form

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Section 2 – Male patients

1. Is Cialis being used for treatment of pulmonary arterial hypertension (PAH)?	**Yes** **SKIP** to Question **14**	**No** Proceed to Question **2**
2. Is Cialis being used for treatment of Raynaud's phenomenon?	**Yes** **SKIP** to Question **14**	**No** Proceed to Question **3**
3. Is Cialis being used for preservation/restoration of erectile function after prostatectomy?	**Yes** **SKIP** to Question **14**	**No** Proceed to Question **4**
4. Is Cialis being prescribed for the treatment of signs and symptoms of benign prostatic hypertrophy (BPH)?	**Yes** **SKIP** to Question **10**	**No** Proceed to Question **5**
5. Is the patient 40 years of age or older?	**Yes** **SKIP** to Question **7**	**No** Proceed to Question **6**
6. Is vardenafil being prescribed for the treatment of erectile dysfunction (ED) of organic origin or mixed organic/psychogenic origin, or drug-induced ED where the causative drug cannot be altered or discontinued?	**Yes** Proceed to Question **7**	**No** **STOP** **Coverage not approved**
7. Has the patient tried Viagra (sildenafil) and had an inadequate response?	**Yes** **Sign and date below**	**No** Proceed to Question **8**
8. Has the patient tried Viagra (sildenafil) but was unable to tolerate it due to adverse effects?	**Yes** **Sign and date below**	**No** Proceed to Question **9**
9. Is treatment with Viagra (sildenafil) contraindicated?	**Yes** **Sign and date below**	**No** **STOP** **Coverage not approved**
10. Is Cialis being prescribed at a dose of 5 mg daily?	**Yes** Proceed to Question **11**	**No** **STOP** **Coverage not approved**
11. Has the patient tried tamsulosin [Flomax] or alfuzosin [Uroxatral] and had an inadequate response?	**Yes** **Sign and date below**	**No** Proceed to Question **12**
12. Has the patient tried tamsulosin [Flomax] or alfuzosin [Uroxatral] and was unable to tolerate it due to adverse effects?	**Yes** **Sign and date below**	**No** Proceed to Question **13**
13. Is treatment with tamsulosin [Flomax] or alfuzosin [Uroxatral] contraindicated (for example, due to hypersensitivity)?	**Yes** **Sign and date below**	**No** **STOP** **Coverage not approved**
14. What is the dosing regimen? **Please sign and date below**		

Step 4 **I certify the above is correct and accurate to the best of my knowledge.** Please sign and date:

Prescriber signature _____ Date _____